Bosque Women's Care

505-847-4100

www.bosquewomenscare.com

Date _____

Patient Demographic Information

Name _____ DOB _____

SSN _____ Pharmacy _____ location_____

Preferred method of communication (please check all that apply)	*Provide applicable information*	*May we leave a message (may include health information)*
email [ ]		Yes / no
alternate email[ ]		Yes / no
home phone [ ]		Yes / no
cell phone [ ]		Yes / no
other phone [ ]		Yes / no
mail [ ]	Address_____ City _____St _____ Zip _____	Yes / no

May we send reminder text messages to your cell? Yes No
May we send reminder messages to your email? Yes No
Cell provider (AT&T, Verizon, etc.) _____

Emergency contact _____Phone Number _____

Ethnicity [ ] non-Hispanic [ ] Hispanic [ ] prefer not to answer

Preferred language [ ] English [ ] Spanish [ ] other _____

Race _____[ ] prefer not to answer

<u>Insurance Information</u>

Insurance company/Policy Name_____

Relationship to insured [ ] self _____DOB of insured _____

ID number _____ group number _____

Bosque Women's Care
505-847-4100
www.bosquewomenscare.com

Date _____

Patient Health Information

Name _____ DOB _____

Primary Care Provider _____

Referring provider _____

Reason for visit _____

Past medical history

[ ] diabetes [ ] heart attack [ ] high blood pressure [ ] asthma [ ] low thyroid
[ ] stroke [ ] kidney disease [ ] cancer [ ] migraines [ ] respiratory disease
[ ] depression [ ] osteoporosis [ ] deep vein thrombosis
[ ] Other_____

Past surgical history

Surgery	*Reason*	*Complications*	*Year*

Obstetrical history

Number of pregnancies _____ number of births _____ living children _____
Number of miscarriages _____ number of terminations _____

Year	*Vaginal or c-section*	*Complications in pregnancy or birth*

Gynecologic history

Age when periods began _____ How often do you have your period _____

How many days do your periods last _____ If menopausal, age when your periods stopped _____

Do you experience…
[ ] severe cramps [ ] passing clots [ ] heavy periods [ ] PMS/mood problems

Have you ever had an abnormal pap smear? Yes No When _____

Result _____ treatment/followup _____

Have you ever had a sexually transmitted infection?
[ ] gonorrhea [ ]Chlamydia [ ] Herpes [ ] HIV/AIDS
[ ] syphilis [ ] genital warts [ ] trichomonas [ ] PID/tubal abscess

Are you currently sexually active? Yes No Have you ever been? Yes No

Are you sexually active with [ ] men [ ] women [ ] both

Current birth control method _____

Medications (include herbs, vitamins, supplements) *[ ] see separate sheet*

Name	*Dose*	*How often*	*reason*

Allergies

Substance/medication	*reaction*

Family history *(Please indicate any medical problems in your family)*

Father [ ] healthy_____ living? Yes / No

Mother [ ] healthy _____ living? Yes / No

Brother(s) [ ] healthy _____

Sister(s) [ ] healthy _____

Any family members with the following cancers?

	(circle)	Relationship to you
Breast cancer	Yes No	
Uterine cancer	Yes No	
Ovarian cancer	Yes No	
Colon cancer	Yes No	

Health maintenance

When was your last…	*Result*	*Ordering doctor*
Pap smear		
Mammogram		
Bone density		
Colonoscopy		
Bloodwork		

Habits and social history

Do you smoke? Yes No Have you ever smoked? Yes No When did you quit? _____
Do you use other forms of tobacco? Yes No _____
Do you smoke Marijuana? Yes No How often? [ ] daily [ ] weekly [ ] monthly [ ] 1-2x/year
Do you drink alcohol? Yes No How often? [ ] daily [ ] weekly [ ] monthly [ ] 1-2x/year
How much do you drink? [ ] 1-2 drinks [ ] 3-5 drinks [ ] more than 5 drinks at a time
Do you use other drugs? Yes No _____
Are you [ ] single [ ] dating [ ] long term relationship [ ] married [ ] widow [ ] divorced/separated

Occupation _____ place of work _____

Is there anything else you would like to discuss with the doctor? _____

_____

_____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Bosque Women's Care, P.C., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Bosque Women's Care, P.C., to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I hereby authorize payment of medical benefits directly to Bosque Women's Care, P.C. for my medical treatment rendered by them.

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Bosque Women's Care, P.C. I agree to pay Bosque Women's Care, P.C., the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Bosque Women's Care, P.C. will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Bosque Women's Care, P.C.
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Bosque Women's Care, P.C. appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

- **It is your responsibility to provide us with your most current insurance information.**
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
- **It is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call our billing office at 505-847-4100
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add **$35 to your original balance**. In the event your bank or credit card agency initiates a chargeback on any payments made by credit card, a **$50 service charge will be added to your original balance.** In addition, we may seek all additional legal remedies provided to us under New Mexico law.
- We may charge you a "No Show" fee of $50 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

I have read the above policy regarding my financial responsibility to Bosque Women's Care, P.C., for providing medical and/or surgical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to

Bosque Women's Care, P.C., the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____Date _____

Guarantor Signature _____ Date _____

Bosque Women's Care
505-847-4100
www.bosquewomenscare.com

Well Woman Exam

A well woman annual exam is a once-a-year visit to your gynecologist or primary care provider for a general health check, that may include (as clinically indicated by age and personal medical history) a breast and pelvic exam, pap smear and follow up on birth control. An annual exam does not include discussion of new problems or detailed review of chronic conditions such as thyroid, acne, missing periods, irregular bleeding, hormone replacement, etc. Annual exams are also called routine check-up, yearly exam, annual pap and preventive visit.

According to the American College of Obstetricians and Gynecologists the preventive annual exam should include the annual physical exam, including assessing current health status, nutrition, physical activity, sexual practices, and tobacco, alcohol, and drug use. Across age groups, the standard physical exam also includes height, weight, body mass index (BMI), and blood pressure. Information will also be provided regarding which vaccinations are recommended by age and risk group, including the flu shot and HPV. Annual testing for Chlamydia and gonorrhea is recommended for all sexually active adolescents and young women up to age 26.

If you have scheduled a "well woman" visit but also want to address a problem or other health issues at the same time as your "well woman" exam, **there will be an additional charge** for the discussion and or treatment of this problem or health issue. ***According to Current Procedural Terminology (CPT) coding guidelines which we follow as required by your insurance plan, a problem is not included in a "well woman" exam and should be billed separately.***

If you prefer, you may schedule a separate visit on another day to address the problems you are having or to address the problems that arise in your annual exam. However, we are happy to provide treatment for problems on the same day as your "well woman" with the understanding that your insurance may require a co-pay or apply this additional charge to your deductible. Sometimes it makes more sense to address issues during the well woman to save you time and keep you from having to see another physician for the problems our physicians can address.

I have read the above information concerning "well woman" visits.

_____
Printed name

_____ _____
Signature Date

Bosque Women's Care
505-847-4100
www.bosquewomenscare.com

TCPA CONSENT FORM

To comply with the **Telephone Consumer Protection Act,** consent is required to send our patients non-emergency, automated phone calls and/or text messages regarding patient appointments and reminders for upcoming scheduled visits.

☐ Yes, I consent to receive automated phone calls, emails, and/or text messages from BWC

☐ Yes, I consent to video and/or telephone visits

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Bosque Women's Care providing health care services to me via telemedicine. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent in writing at any time by contacting Bosque Women's Care. As long as this consent is in force (has not been revoked) Bosque Women's Care may provider health care services to me via telemedicine without the need for me to sign another consent form.

No, I do not consent to receive:

- ☐ automated phone calls and text messages from BWC
- ☐ emails from BWC

Consent shall continue during the time I am a patient at Bosque Women's Care unless revoked by me in writing.

_____ _____ _____

Date Signature Printed Name

Bosque Women's Care
505-847-4100
Bosquewomenscare.com

Date _____

Name _____

DOB _____ Age _____

ACKNOWLEDGEMENT OF RECEIPT OFNOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Bosque Women's Care, P.C., reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website, www.bosquewomenscare.com, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

My provider may submit information to my referring provider and/or my primary care physician for the continuity of my care. If I do not want information sent to my other provider I will notify the staff in writing that this is not acceptable.

_____

Patient/Legal Representative Signature Date

_____

Relationship to Patient Expiration Date of Authorization

_____

Witness Date

The following names are of people I would like to be involved or have access to my protected health information (PHI) on a routine basis. I give permission for Bosque Women's Care, P.C., to share my PHI with:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship